DEPARTMENT OF HEALTH AND FAMILY SERVICES **STATE OF WISCONSIN**
Division of Health Care Financing
HCF 1159 (Rev. 02/04)

WISCONSIN MEDICAID
OTHER COVERAGE DISCREPANCY REPORT

Wisconsin Medicaid requires information to enable Medicaid to authorize and pay for medical services provided to eligible recipients.

Recipients are required to give providers full, correct, and truthful information for the submission of correct and complete claims for Medicaid reimbursement. This information should include, but is not limited to, information concerning eligibility status, accurate name, address, and Medicaid identification number (HFS 104.02[4], Wis. Admin. Code).

Under s. 49.45(4), Wis. Stats., personally identifiable information about Medicaid applicants and recipients is confidential and is used for purposes directly related to Medicaid administration such as determining eligibility of the applicant or processing provider claims for reimbursement.

The use of this form is voluntary; providers may develop their own form as long as it includes all the information on this form. Attach additional pages if more space is needed.

INSTRUCTIONS: Use this form to notify Wisconsin Medicaid of discrepancies between other health care coverage information obtained through the Eligibility Verification System and information received from another source. Always complete Sections I and IV. Complete Sections II and/or III as appropriate. Wisconsin Medicaid will verify the information provided and update the recipient's file (if applicable). Attach photocopies of current insurance cards along with any available documentation, such as Explanation of Benefits reports and benefit coverage dates/denials. This will allow records to be updated more quickly. Type or print clearly.

SECTION I ¾ PROVIDER AND RECIPIENT INFORMATION

Name — Provider (Last, First, Middle Initial)		Wisconsin Medicaid Provider Number
Name — Recipient (Last, First, Middle Initial)	Date of Birth — Recipient	Recipient Medicaid Identification Number

SECTION II ¾ MEDICARE PART A AND B COVERAGE

Medicare / HIC Number

☐ Add		☐ Remove	
☐ Part A Coverage	Start Date	☐ Part A Coverage	End Date
☐ Part B Coverage	Start Date	☐ Part B Coverage	End Date

SECTION III ¾ COMMERCIAL INSURANCE, MEDICARE SUPPLEMENTAL, AND MEDICARE MANAGED CARE COVERAGE

☐ Add	☐ HMO	☐ Medicare Managed Care
☐ Remove	☐ Medicare Supplement	☐ Other

Name — Insurance Company

Address — Insurance Company (Street, City, State, Zip Code)

Name — Policyholder (Last, First, Middle Initial)		Social Security Number — Policyholder
Policy Number	Coverage Start Date	Coverage End Date

Recipient Left HMO Service Area ☐ Yes ☐ No	Date Recipient Left HMO Service Area (If Applicable)

SECTION IV ¾ REPORT INFORMATION

Name — Individual Completing This Report	Date Signed	Telephone Number / Extension
Name — Source of Information Included on This Report		Telephone Number / Extension

Mail to	Fax to	Comments
Wisconsin Medicaid Coordination of Benefits 6406 Bridge Rd Madison WI 53784-6220	Coordination of Benefits (608) 221-4567	(Attach additional pages if necessary.)

Reset Form